Yvonne Montoz 6-10-05

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address SPINE HOSPITAL OF TEXAS 18600 N. Hardy Oak Blvd. San Antonio, TX 78258-4206	MDR Tracking No.: M4-05-2312-01 TWCC No.: [redacted] Injured Employee's Name: [redacted]
Respondent's Name and Address NORTHSIDE ISD CMI Barron Risk Management Services 613 NW Loop 410, Suite 800 San Antonio, TX 78216 Carrier Representative Box 03	Date of Injury: [redacted] Employer's Name: [redacted] Insurance Carrier's No.: [redacted]

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PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/19/04	08/21/04	Surgical Admission	$24,790.60 less $13,876.92 (additional payment) $10,913.68	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"Payment is not in accordance with TWCC Fee Guideline. Payment is not in accordance with the Acute Inpatient Stop-Loss portion of the Fee Guideline. Used by carrier for charges for which no "MAR" is established." The carrier improperly denied or reduced payment in this instance pursuant to Texas Administrative Code (TAC) Sections 133 and 134. The payment exception codes provided on an EOB indicate payment pursuant to the TAC and the Commission instructions. However, the carrier has not provided payment pursuant to the TWCC Fee Guidelines in effect at the time of the date of service. Specifically, TWCC Rule 134.301(c)(6) requires payment of 75% of total audited charges for billed charges that reach the stop-loss threshold of $40,000.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier paid $21,77.19 on 09/30/04 and indicated EOB codes: F – Fee guideline MAR reduction; G –Unbundling; and 480 – Per diem allowance per ACIHFG. Carrier's TWCC-60 of 11/15/04 states: A re-review of the bill in question revealed the wrong explanation code was given on most of the charges, i.e. "G" should have been "M – no MAR". A supplemental payment of $13,876.92 has been recommended. This payment represents 75% of charges on everything except for the implantables, which have already been paid at fair and reasonable and the OR charges. An ALJ has ruled in more than one instance that carriers have the right to review and audit charges including, but presumably not limited to implantables. The facility's OR charges are double the average OR charge in San Antonio. Therefore, we have paid fair and reasonable, which is approximately $2000 per hour for the San Antonio area. The patient was in the OR 3 hours and 35 minutes. We have rounded up to 4 hours. This brings the total amount paid to the provider up to $35,650.11.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

In particular, this surgical admission resulted in a total length of stay of 2 days based upon: L4 decompressive laminectomy, L4-5 bilateral posterolumbar interbody fusion with Saber cages and bone morphogenic protein, L4-5 posterolateral fusion with local autograft and bone marrow aspirate, and L4-5 instrumentation with Texas Scottish Rite Hospital pedicles screw and rod. Accordingly, the standard per diem amount due for this admission is equal to $2,236.00 (2 times $1,118). In addition, the hospital is entitled to additional reimbursement for implantables/MRIs/CAT Scans/pharmaceuticals.

Provider charged $35,522.16 per the UB-92 for the implantables.
Implantable invoice total submitted by provider is $17,903.64
Carrier reimbursement of implant[redacted] $19,537.19.

The provider billed for $62,08[redacted]ed payments totaling $35,650.11. Therefore, considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that **no** additional reimbursem[redacted] for these services.

PART VI: COMMISSION D[redacted]CISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

Authorized Signature	Allen McDonald Typed Name	06/09/2005 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on 06/09/05. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____